Oklahoma Health Care Authority
REQUEST FOR INFORMATION
CARE COORDINATION FOR THE AGED, BLIND, AND DISABLED

SECTION I: GENERAL INFORMATION

1.1 ANNOUNCEMENT

The Oklahoma Health Care Authority (hereinafter OHCA) is issuing this Request for Information (hereinafter RFI) to obtain information from prospective Respondents regarding Care Coordination models to efficiently serve the Oklahoma Medicaid (hereinafter SoonerCare) programs' eligible aged, blind, and disabled members (hereinafter ABD). It is the intent of the Legislature and Governor's Office, per House Bill 1566, for OHCA to employ market driven solution(s) toward the aim of providing access to quality care, for less cost, to ABD SoonerCare members. OHCA will use information obtained from Respondents and other Stakeholders to design comprehensive model(s) to administer in the future.

1.2 OBJECTIVES

OHCA's major objectives for a Care Coordination model are as follows:

1. Determine the best market-based approach(es) to serving Oklahoma's ABD members;
2. Improve health outcomes by ensuring members receive the most clinically appropriate evidence-based health care services delivered in a person-centered manner and in the least restrictive environment;
3. Incorporate requirements for the use of standard, performance-based quality metrics and value-based payment systems;
4. Improve coordination among providers, thereby reducing unnecessary costs, while maintaining high quality of care;
5. Strengthen providers' accountability for attainment of improved health outcomes;
6. Maintain and enhance effective systems of Long-Term Services and Support;
7. Provide efficient and effective health services and care coordination to eligible members;
8. Realize administrative and health care cost savings through efficient management and appropriate utilization of services; and
9. Ensure provider and member satisfaction with appropriate benefits.

1.3 POINT OF CONTACT

This RFI is issued by OHCA and OHCA is the sole point of contact from the date of release of this RFI through the closing date as follows:

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
Attention: Amy Bradt
Phone (405) 522-7709
E-mail: Amy.Bradt@okhca.org

1.4 RFI TIMETABLE *(All dates are estimates and subject to change)*

RFI available on OHCA website	June 22, 2015

All Respondent questions due	July 6, 2015
Answers posted on OHCA website	July 17, 2015
RFI Responses due	August 3, 2015
Demonstrations	August 10-21, 2015

1.5 RFI CLOSING DATE

A. Responses submitted in accordance with this RFI must be received by OHCA no later than **3:00PM Central Time (CT) on August 3, 2015**. Responses should be emailed to the Point of Contact in Section 1.3. Responses received after the closing time and date will not be accepted.

B. After reviewing submissions, OHCA may invite some or all Respondents to demonstrate their Care Coordination models at OHCA's offices in Oklahoma City.

SECTION II: BACKGROUND

2.1 OKLAHOMA HEALTH CARE AUTHORITY (OHCA):

OHCA is the sole state agency that administers SoonerCare. Medicaid is a federal and state entitlement program that provides funding for medical benefits to low-income individuals who have inadequate or no health insurance coverage. Medicaid guarantees coverage for basic health and long-term care services based upon financial, categorical, and/or resource eligibility. Created as Title XIX of the Social Security Act in 1965, Medicaid is administered at the federal level by the Centers for Medicare and Medicaid Services (hereinafter CMS) within the Department of Health and Human Services (HHS). CMS establishes and monitors certain requirements concerning funding, eligibility standards and quality and scope of medical services. States have the flexibility to determine some aspects of their own programs, such as setting provider reimbursement rates and the broadening of the eligibility requirements and benefits offered within certain federal parameters.

2.2 OVERVIEW OF THE ABD POPULATION:

During State Fiscal Year 2014 a total of 16.4 percent of all SoonerCare enrollees were Aged, Blind, or Disabled and accounted for over 46 percent of all SoonerCare expenditures. Additional information may be found in the Respondent's Library and at http://okhca.org/ under 'Research and Statistics'.

2.3 DEFINITIONS

A. Aged means an individual whose age is established as 65 years or older.

B. Blind means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

C. Physically Disabled means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

D. IDD means individuals with intellectual and/or developmental disabilities.

E. LTC means Long Term Care.

F. Disabled means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

SECTION III: RFI INFORMATION AND QUESTIONS

3.1 CARE COORDINATION MODELS

The models listed herein are known to OHCA and are provided as framework. The Respondent may select one or a combination of such to fulfill the needs of eligible ABD SoonerCare enrollees.

A. Medicaid Fee for Service – A healthcare model where healthcare providers are paid for each service provided.

B. Risk-based Arrangements- A healthcare model that reduces spending for its members and the provider receives an incentive payment with a portion of the savings.

C. Fully Capitated Managed Care Organization (MCO) - A model in which capitation payments control the use of health care resources by putting the providers at financial risk for services. To ensure that members do not receive suboptimal care through under-utilization of health care services, MCOs measure the rates of resource utilization in the providers' services.

D. Partially Capitated- A model in which members are enrolled with a primary care practitioner who is responsible for providing primary and preventive care and coordinating, and monitoring access to other medically necessary services. The providers of the other services are reimbursed on a fee-for-service basis.

E. Medicare Shared Savings Program- Established by section 3022 of the Affordable Care Act, the Shared Savings Program is a key component of the Medicare delivery system reform initiatives included in the Affordable Care Act and is a new approach to the delivery of health care. Congress created the Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

F. The Program of All-Inclusive Care for the Elderly (PACE) - PACE provides care and services in the home, the community, and the PACE center. This model has contracts with providers in the community to make sure members get the care they need.

G. Shared Savings- Designed to reward entities that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Entities may choose to organize as an ACO (as recognized by CMS). Shared Savings Programs are typically comprised of groups of doctors and other health care providers who voluntarily work together with payers to give high quality service to patients. Many shared savings programs continue to pay individual providers and suppliers for specific items and services through current payment systems. The payer, in cooperation with the entities, develops benchmarks against which performance is measured to assess whether the entity qualifies to receive shared savings, or potentially be held accountable for losses.

H. Health Home- A model that involves the coordinated care of members overall health care needs, and in which the member is an active partner in their care.

I. Long-Term Support and Services (LTSS) – The Medicaid program allows for the coverage of Long-Term Care Services through several vehicles and over a continuum of settings. This includes Institutional Care and Home and Community-Based Long-Term Care Services and Supports.

J. Home & Community Based Services (HCBS) - Home and community-based services provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

K. Other

3.2 General RFI Information

OHCA is considering contracting with a vendor(s) for Care Coordination of the ABD population. RFI responses will be used to determine the market feasibility of a variety of approaches, generate discussion and input among stakeholders, and result in a recommendation for potential models serving a variety of geographic areas and populations. OHCA understands there may not be a single Care Coordination model that meets all of our needs, and a model(s) may be feasible in statewide, regional, or county-level areas. Respondents may present one or several of the models listed on the RFI Cover Page. If the Respondent selects more than one model indicated on the Cover Sheet, a separate response needs to be submitted with all applicable forms completed.

3.3 Scope of Work

Respondents are asked to propose a Care Coordination model for Oklahoma eligible ABD SoonerCare enrollees according to the outline below:

A. High-Level description of the recommended Patient-Centered service delivery model
   1. Name and describe Respondents chosen model including reason for selecting the model
   2. Describe how the model addresses the needs of the ABD patient population
   3. Explain Respondents approach for implementation of the model

B. Populations Served
   1. Identify proposed eligible populations *(All members or target specific populations based on geographic areas, aid category, specific health conditions, etc.)*
   2. For each of the populations selected, state whether services would be provided statewide, within certain county(s), or will Respondent employ regionalization
      i. Define which county(s) in which the model would operate
      ii. Define which county(s) included in each region

C. Covered Services and Benefits
   1. Describe proposed covered services and benefits for each population
   2. Describe the clinical effectiveness and evidence-base supporting the proposed covered services and benefits
   3. Explain reason for any proposed non-covered services and benefits

D. Provider Network
   1. Describe provider network recruitment and retention, including types of providers *(for example primary care, specialty care, dental, HCBS, case/care management, LTC, other, etc.)*

E. Provider Payment Structure

1. Explain provider payment methodology, assumptions, and constraints
    a. Specific to covered benefits and services (As listed in Section 3.3, Item C)
    b. Specific to other benefits and services
    c. Show estimated amounts of provider payments for evidence-based performance outcomes *(for example amounts of withholds, performance payments based on quality metrics, etc.)*

F. State Payment Structure

1. Explain how payments are made by the state to the party(s) responsible for the objectives of the recommended model (As listed in Section 3.1, Items A-K)
    a. Methodology
    b. Assumptions
    c. Constraints
2. Explain how proposed payments comply with existing and proposed Federal and State requirements

G. Impact of Model

1. Explain estimated implementation costs and anticipated savings, for years 1 through 5.
    a. Methodology
    b. Assumptions
    c. Constraints
2. Describe the quality and anticipated effect of the model on population health outcomes as related to *(materials provided in Respondent's Library)*:
    a. CMS recommended benchmarks
    b. State identified areas including preventive screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use
    c. Core measures identified within the Oklahoma Health Plan (OHIP) 2020
    d. Respondent suggestions for other benchmarks
    e. Considerations for Value-Based performance designs, specifically those that support and align with objectives identified within the Oklahoma State Innovation Model design

H. Anticipated Overarching Timelines *(including key activities and milestones)*

1. Development
2. Transition/Readiness Activities
3. Implementation of member enrollment
4. Implementation of member service delivery

I. Market Feasibility

Provide considerations, observations and potential opportunities and/or threats related to:

1. Environmental conditions
2. Conditions unique to the Oklahoma market
3. Conditions not unique to the Oklahoma market
4. Availability and range of community resources

5. Existing and Proposed Federal regulation(s)
6. Data Attainment, Cross-walking to Medicaid, and Use
7. Coordination of benefits and services between Medicare and Medicaid
8. Alignment of payment structures and goals

J. Approach to Integration with Medicare
   1. Considerations, observations and potential opportunities and threats related to:
      a. Existing and Proposed Federal regulation(s)
      b. Data Attainment, Cross-walking to Medicaid, and Use
      c. Coordination of Benefits and Services between Medicare and Medicaid
      d. Alignment of Payment Structures and Goals

SECTION IV: RESPONSES

4.1 RESPONSE FORMAT

A. Respondents are encouraged to provide all requested information to ensure that their response is most useful to OHCA. Only Respondents who answer all questions will be invited to make a presentation; at its discretion, OHCA may also review the responses that are not complete.

B. Respondents must complete the Cover Page and the Respondent Stability/Experience Form available on the OHCA website with this RFI, which includes indicating which Care Coordination model(s) they recommend and Past Performance. If Respondent is submitting more than one model, both forms must be submitted along with each response.

C. The entire Scope of Work response (As listed in Section 3.3) will not exceed a 50 page limit. Any items over the 50 pages will not be reviewed.

4.2 COST OF PREPARING RESPONSES

A. All costs incurred by the Respondent for response preparation and participation in this informative process will be the sole responsibility of the Respondent. The State will not reimburse any Respondent for any such costs.

B. The State reserves the right to withdraw the RFI at any time during this process. Issuance of this RFI in no way obligates the State to award or issue a contract or to pay any costs incurred by any Respondent as a result of such a withdrawal.

4.3 RETENTION OF RESPONSES

A. Unless otherwise specified in the Oklahoma Open Records Act, Central Purchasing Act, or other applicable law, documents and information a respondent submits are public records and subject to disclosure.

B. If OHCA proceeds with a competitive bid and contract award following this RFI, RFI responses are NOT available to the public or other vendors until the contract is awarded pursuant to Oklahoma Administrative Code.

C. Respondents claiming any portion of their response as proprietary or confidential must specifically identify what documents or portions of documents they consider confidential and submit an additional copy of the response with this information redacted. OHCA shall make the final decision as to whether the documentation or information is confidential.

D. If the Respondent provides a redacted copy of its response and OHCA

appropriately supplies the redacted bid to another party under the Oklahoma Open Records Act or other statutory or regulatory requirements, the Respondent agrees to indemnify OHCA and step in to defend its interest in protecting the referenced redacted material.

4.4 ACCEPTANCE OF RESPONSES

A. The State will accept all responses submitted according to the requirements and deadlines specified in this RFI. Responses must be complete when submitted and should clearly describe the Respondents' ability to meet the requirements of the RFI and the needs of the State.

B. OHCA may ask any Respondent for written clarification of their response.

SECTION V: VENDOR PRESENTATIONS

A. Based on RFI responses, OHCA may invite some Respondents to make oral presentations about their programs, capabilities, and approaches to OHCA staff. OHCA may also request telephone interviews with key personnel at the Respondent's organization in addition to or in lieu of a presentation.

B. Only Respondents who submit complete responses by Monday, August 3, 2015 will be considered for presentations. OHCA appreciates all responses and may review incomplete responses or those received after the deadline at its discretion.

RESPONDENT STABILITY/EXPERIENCE FORM

1. Select Respondent's organization type:
   - Physician Group Practice
   - Clinic or Ambulatory Surgical Center
   - Hospital
   - Health System
   - Private Insurance Company
   - Health Maintenance Organization
   - State Agency
   - Not-for-Profit
   - Other_____

2. Indicate Respondent's organizational characteristics including the following:
   a. Revenue:

   b. Net Worth:

   c. Number of:
      - Full Time Employees:
      - Part Time Employees:
      - Contracted Employees:

   d. Subsidiaries/D.B.As:

   e. Covered Lives:

   f. Major Lines of Business or Capabilities:

   g. Service Locations:

3. State the number of Health Plans the Respondent currently administers/has administered in the past five years:

4. History serving Medicare, Medicaid, State Employee, and/or Private Insurance Members:
   a. Plan Size (Enrollment and Provider Networks):

   b. Included Services:

   c. Reimbursement:

   d. States/Programs Served: